

Maryland Immunization Information System (ImmuNet) Opt-out Form

Maryland's Immunization Information System (ImmuNet) is a secure health information system containing the names and immunization history of people who have received vaccinations in Maryland. This information is available only to authorized health care providers, child care providers, and schools. Participation in ImmuNet is voluntary and you may opt out at any time by completing this opt-out form.

You may download and print this form, or request a hard copy by contacting the ImmuNet Help Desk at dhmh.mdimmunet@maryland.gov or 410-935-9295.

Please complete the information for the person whose immunization record should not be shared with participants of the ImmuNet program.

Client Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Email address: _____

Information about the person completing this form

Information about the person completing the opt-out request (this information will be used to contact you if this form is incomplete or unclear, and will be filed as legal documentation of the opt-out request).

☐ Same as Client Information above (if not, please provide the information below)

Relationship to client: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Email address: _____

Signature

By checking the box below, I understand that my request to opt-out of ImmuNet for myself, my minor child, or person for whom I am a legal guardian means that the client's information will not be available to or shared with authorized health care providers. I understand that the Maryland Department of Health and Mental Hygiene (DHMH) and Local Health Departments (LHDs) will still have access to the client's record. Physician or school requests for information must be accompanied by a signed medical release.

I agree: ☐

I declare under penalty of perjury under the laws of the state of Maryland that this information is true and correct, and that I am the client, or am authorized to make decisions for the client listed on this form.

Signature of Person Requesting the Opt-out: _____

Date completed: _____

If you wish to keep a completed copy of your form, please make a copy before submitting the form.

Mail or Fax to

Maryland Department of Health and Mental Hygiene
Center for Immunization - ImmuNet
201 West Preston Street 3rd Floor, Baltimore, MD 21201
Fax: (410) 333-5893